433.463: Drugs: Introduction

(A) Recipient Copayments. The Division requires under certain conditions that recipients make a copayment to the dispensing pharmacy for each prescription for all drugs (whether legend of nonlegend) reimbursable under the Medical Assistance Program. The copayment requirements are detailed in the Division's administrative and billing regulations at 130 CMR 450.130.

(B) Eligible Recipients.

(1)(a) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for legend drugs as described in 130 CMR 433.463(C).

(b) For Medical Assistance recipients under age 18, the Division pays for nonlegend drugs as described in 130 CMR 433.463(C). For Medical Assistance recipients aged 18 or older, the Division pays only for nonlegend drugs that are certified to be necessary for the life and safety of the recipient. The Division will reimburse for nonlegend drugs as long as the provider's claim has attached to it a written certification on letterhead from the recipient's primary care physician that attests that such drugs are medically necessary for the life and safety of the recipient and that contains a substantiating medical explanation. However, this certification is not required for insulin, which is reimbursable provided there is a prescription for it.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Service Limitations. The Division will pay for legend drugs that are approved by the U.S. Food and Drug Administration, except as outlined below. The Division will pay for the nonlegend drugs listed in the Nonlegend Drug List; this list is sent to pharmacies by the Division. In order to be reimbursable, legend and nonlegend drugs must be manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990. A list of the companies that have signed rebate agreements is sent to pharmacies by the Division.

(1) Interchangeable Drug Products. For drugs listed in the Massachusetts List of Interchangeable Drugs (105 CMR 720.000) or any supplement thereof, the Division will pay no more than the maximum allowable cost (MAC) or Massachusetts maximum allowable cost (MMAC) unless:

(a) the prescriber has requested and received prior authorization from the Division for a nongeneric multiple-source drug (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation stating the reasons the recipient's medical condition requires the nongeneric drug; or

(b) the prescriber has written on the face of the prescription in his own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(2) Minor Tranquilizers.

(a) The Division will not pay for any drug that is classified by the Division as a minor tranquilizer, with the following exceptions:

1. generic chlordiazepoxide;
2. generic diazepam;
3. generic lorazepam;
4. generic oxazepam; and
5. generic temazepam.

The list of drugs that the Division has classified as minor tranquilizers is sent to pharmacies by the Division.

(b) The Division will pay for otherwise nonreimbursable minor tranquilizers only if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(c) In an emergency where a recipient is brought to a hospital emergency room, if the prescriber wishes to prescribe an otherwise nonreimbursable minor tranquilizer for that emergency, the Division will pay a hospital pharmacy for a maximum 14-day supply without prior authorization. The Division will pay only a hospital pharmacy.

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(3) Antiulcer Drugs.

(a) The Division pays for a maximum 60-day supply of antiulcer drugs per recipient per six-month period, commencing with the first prescription filled (new or refill) after December 1, 1990. The Division will pay for additional supplies of these drugs within the six-month period only if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation indicating that the recipient is on maintenance therapy for one of the following conditions or must submit other documentation of medical necessity:

1. duodenal or gastric ulcer;
2. Zollinger-Ellison syndrome; or
3. gastroesophageal reflux disease.

(b) Antiulcer drugs include, but are not limited to, such drugs as histamine (H_2) receptor antagonists and sucralfate.

(c) Each days's supply of different antiulcer drugs prescribed for use on the same day will be counted as separate days' supplies. For example, a physician has prescribed 100 sucralfate tablets with a dosage of one tablet four times a day (a 25-day supply) and has also prescribed for the same recipient for use on the same days 50 ranitidine tablets with a dosage of one tablet twice a day (a 25-day supply). For purposes of calculating the days' supply of antiulcer drugs, the days' supply of each of the dispensed drug is added together. Therefore, this recipient would now have used a 50-day supply of antiulcer drugs.

(4) Potassium Supplements. The Division pays for those potassium supplements listed in Appendix I of the *Pharmacy Manual*. This list is sent to pharmacies by the Division. The Division will also pay for a potassium supplement not listed in Appendix I if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of the medical necessity of the drug, including the reason why none listed in Appendix I would suffice.

(5) Topical Acne Drugs. The Division does not pay for topical acne products unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). The Division will grant prior authorization only for cases of severe acne. With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(6) Cosmetic Drugs. The Division does not pay for drugs used for cosmetic purposes or for hair growth.

(7) Nicorette. The Division does not pay for Nicorette or any other drug used for smoking cessation.

(8) Methyl Phenidate (Ritaline) and Amphetamines. The Division does not pay for methyl phenidate (Ritalin), amphetamines (including amphetamines in combination), or any other drugs when they are used for control of the appetite. When precribed for the treatment of hyperkinesis, however, such drugs are reimbursable without prior authorization until the recipient reaches his or her 17th birthday if the prescriber writes on the prescription the words "for hyperkinesis." All other uses of amphetamines require prior authorization (see 130 CMR 433.465).

(9) Nonlegend Vitamins. The Division pays for nonlegend vitamins only if they are included in the Nonlegend Drug List and then only when they are dispensed to infants or children until they reach their third birthday or to pregnant women. General multiple vitamins NF (National Formulary) in a unit of 100 are reimbursable without age restriction.

(10) Fluorides. The Division does not pay for plain fluorides for recipients aged 12 and over unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(11) Iron. The Division pays only for those iron preparations included in the Nonlegend Drug List.

(12) Persantine. The Division does not pay for Persantine or any other dipyridamole for which the U.S. Food and Drug Administration has granted the labeling and use indication described in 130 CMR 433.463(B)(12) unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). The Division will

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grant prior authorization only for an indication approved by the U.S. Food and Drug Administration (currently as an adjunct to coumarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac-valve replacement).

(13) Less-Than-Effective Drugs. The Division does not pay for drug products (including identical, similiar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a notice of opportunity for hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications. (Examples of drug products affected by 130 CMR 433.463(C)(13) are listed in Appendix H of the *Physician Manual*).

(14) Immunizing Biologicals and Tubercular Drugs.

(a) Immunizing biologicals and tubercular (TB) drugs available free of charge through local boards of public health or through the Massachusetts Department of Public Health are not reimbursable. If the recipient has a prescription, however, the Division will pay for the following drugs for a nonambulatory recipient who cannot attend one of the Department of Public Health clinics: Isoniazid, Myambutal, and P.A.S. All other such drugs require prior authorization (see 130 CMR 433.465).

(b) 130 CMR 433.463(C)(14)(a) notwithstanding, the Division does pay for pneumococcal vaccine when dispensed to a noninstitutionalized recipient.

(15) Antacids. The Division pays only for antacids dispensed to a noninstitutionalized recipient. Reimbursable anatacids include those legend drugs manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990, and only those nonlegend drugs listed in Appendix F of the *Pharmacy Manual* that are manufactured by companies that have signed rebate agreements. A list of the companies that have signed rebate agreeements is sent to pharmacies by the Division. The Division pays for other antacids only if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(16) Laxatives and Stool Softeners. The Division does not pay for laxatives or stool softeners unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(17) Cough and Cold Preparations. The Division does not pay for legend or nonlegend preparations that contain a decongestant, antitussive, or expectorant as a major ingredient, or any drug used for the symptomatic relief of coughs and colds, when they are dispensed to a noninstitutionalized recipient.

(18) Propoxyphene. The Division does not pay for any drug product that contains propoxyphene, except:

(a) propoxyphene hydrochloride 32 mg; and

(b) propoxyphene hydrochloride 65 mg, unless the prescriber has requested and received prior authorization from the Division (*see* 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(19) Hexachlorophene Preparations. The Division does not pay for preparations containing hexachlorophene, U.S.P. as the major active ingredient unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(20) Sex-Reassignment Hormone Therapy. The Division does not pay for drugs related to sex-reassignment surgery, with the exception of postsurgery hormone therapy, unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.465). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(21) Unit-Dose Distribution System. The Division does not pay any additional fees for dispensing drugs in unit dose.

(22) Fertility Drugs. The Divison does not pay for any drugs used to treat male or female infertility (specifically including, but not limited to, A.P.L., chorionic gonadotropins, Clomid, clomiphines, hCg, menotropins, Milphene, Pergonal, Pregnyl, Profasi, Profasi HP, and Serophene).

433.464: Drugs: Prescription Requirements

(A) Written Prescription Requirements. Except as provided in 130 CMR 433.464(B), legend drugs and nonlegend drugs are reimbursable only after the pharmacy has obtained a written prescription signed by an authorized prescriber. All prescriptions written by prescribers in Massachusetts must be written on a prescription form approved by the Massachusetts Department of Public Health (Generic Drug Law, M.G.L. c. 112, § 12D). The prescription must contain the following information:

(1) the recipient's name and address;
(2) the drug name, strength, dosage schedule, and quantity;
(3) the number of authorized refills;
(4) the prescriber's name, address, and Drug Enforcement Administration (DEA) number when available;
(5) the prescriber's signature (preprinted or rubber-stamped signatures are invalid); and
(6) the date on which the prescription was signed by the prescriber.

(B) Waiver of Written Prescription Requirement. 130 CMR 433.464(A) notwithstanding, an oral/telephone prescription order, as defined in M.G.L. c. 94C, § 20(c), and containing the information listed in 130 CMR 433.464(A)(1) through (A)(4), is recognized as a valid prescription only in the following cases.

(1) The drug prescribed is listed in Schedule VI of the Massachusetts Controlled Substances Act.

(2) For a recipient in a nursing home or rest home: the drug prescribed is listed in Schedule III, IV, V, or VI of the Massachusetts Controlled Substances Act.

(3) The prescriber states that an emergency exists. In an emergency, the drug must be dispensed in compliance with state and federal regulations and in accordance with the following requirements:

(a) the drug quantity may not exceed a 72-hour supply; and
(b) the prescription may not be refilled.

The prescriber must give an original written prescription that conforms with 130 CMR 433.464(A) to the pharmacy within 72 hours after the oral/telephone order for a drug listed in Schedule II of the Massachusetts Controlled Substances Act, or within seven days after the oral/telephone order for a drug listed in Schedule III, IV, or V of the Massachusetts Controlled Substances Act.

(C) Refills. A prescription may be refilled for the number of times authorized by the prescriber, to a maximum of five refills. No refill may be dispensed after six months from the date of the original prescription. The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

433.465: Drugs: Prior Authorization Requirements

(A) If the limitations on reimbursable drugs specified in 130 CMR 433.463(B) would result in inadequate treatment for a diagnosed medical condition, the physician may submit a written request for prior authorization for an otherwise nonreimbursable drug.

(B) All prior authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*. If the Division approves the request, it will notify the physician and assign a prior authorization number that must be written on the prescription.

433.466: Durable Medical Equipment and Medical/Surgical Supplies: Introduction

(A) Eligible Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for the purchase, rental, and repair of durable medical equipment, and the purchase of medical/surgical supplies. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

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(B) Reimbursable Equipment. Durable medical equipment consists of products that are fabricated primarily and customarily to fulfill a medical purpose, are generally not useful in the absence of illness or injury, can withstand repeated use over an extended period of time, and are appropriate for home use. Payment for durable medical equipment and medical/surgical supplies is considered by the Division on an individual basis.

(C) Nonreimbursable Services.

(1) The Division will not pay for durable medical equipment or medical/surgical supplies that are experimental in nature, unless prior authorization has been obtained.

(2) The Division will not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose will not be considered medical equipment, even if such equipment has a medically related use. For example, equipment whose primary function is environmental control, comfort, or convenience, or that is provided primarily for the comfort or convenience of a person caring for the recipient, or that is customarily used to promote physical fitness is not reimbursable.

(3) The Division will not pay for durable medical equipment or medical/surgical supplies that are not both necessary and reasonable for the treatment of a recipient's medical condition. This includes:

(a) items that cannot reasonably be expected to make a meaningful contribution to the treatment of a recipient's illness or injury or to the improved functioning of a recipient's malformed body member; and

(b) items that are substantially more costly than a medically appropriate and feasible alternative piece of equipment or that serve essentially the same purpose as equipment already available to the recipient.

(4) The Division will not pay for standard medical and surgical treatment products, goods, and health-related items provided to recipients who reside in hospitals, nursing homes, or rehabilitation facilities.

433.467: Durable Medical Equipment and Medical/Surgical Supplies: Prescription Requirements

The purchase or rental of durable medical equipment and the purchase of medical/surgical supplies are reimbursable only when prescribed in writing by a licensed physician. The equipment and repair services must be furnished by a participating Medical Assistance provider. The prescription must include the following information:

(A) the recipient's name, address and recipient identification number;

(B) the specific identification of the prescribed equipment or supplies;

(C) the medical justification for use of the equipment or supplies;

(D) the estimated length of time that the equipment or supplies will be used by the recipient;

(E) the location in which the recipient will customarily use the equipment or supplies;

(F) the physician's address and telephone number; and

(G) the date on which the prescription was signed by the physician.

433.468: Durable Medical Equipment and Medical/Surgical Supplies: Prior Authorization Requirements

The Division requires that the durable medical equipment provider obtain prior authorization as a prerequisite for payment for certain durable medical equipment, including hospital beds and wheelchairs, certain durable medical equipment repair services, and certain medical/surgical supplies. The request for prior authorization must be submitted by the durable medical equipment provider on the appropriate Division form. The physician must complete and sign Sections 1, 2, and 3 of this prior authorization form (*see* the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*).

433.469: Oxygen and Respiratory Therapy Equipment

(A) Eligible Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for oxygen and respiratory therapy equipment as defined in 130 CMR 433.401. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Nonreimbursable Services.

(1) The Division will not pay for oxygen or respiratory therapy equipment for recipients in acute, chronic, or rehabilitation hospitals, or in state schools.

(2) The Division will not pay for oxygen or respiratory therapy equipment when prescribed for emergency use or on an "as needed" basis for recipients residing in nursing facilities.

(3) The Division will not pay for respiratory therapy equipment that is investigative or experimental in nature, unless prior authorization from the Division has been obtained.

(4) The Division will not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use. For example, equipment whose primary function is environmental control, comfort, or convenience is not reimbursable.

(5) The Division will not pay for oxygen or respiratory therapy equipment that is not both necessary and reasonable for the treatment of a recipient's pulmonary condition. This includes:

(a) equipment or services that cannot reasonably be expected to make a meaningful contribution to the treatment of a recipient's pulmonary insufficiency; and

(b) equipment or services that are substantially more costly than a medically appropriate, feasible alternative or that serve essentially the same purpose as equipment already available to the recipient.

(C) Prescription Requirements. The purchase of oxygen and the purchase or rental of respiratory therapy equipment are reimbursable only when prescribed in writing by a licensed physician. The oxygen and the respiratory therapy equipment must be furnished by a participating Medical Assistance provider. The prescription must include the following information:

(1) the recipient's name, address and recipient identification number;
(2) the specific identification of the prescribed oxygen and equipment;
(3) the medical justification for the use of the oxygen and equipment;
(4) for oxygen: the prescribed liter flow rate and frequency of treatment;
(5) for respiratory therapy equipment: the frequency of use per day;
(6) the estimated length of time the oxygen or equipment will be used by the recipient;
(7) the location in which the recipient will customarily use the oxygen or equipment;
(8) the physician's address and telephone number; and
(9) the date on which the prescription was signed by the physician.

(D) Purchases and Rentals Requiring Prior Authorization. The Division requires that prior authorization be obtained as a prerequisite to payment for the oxygen and respiratory therapy equipment and services listed below.

(1) Purchase of any of the following requires prior authorization:

(a) respiratory therapy equipment costing more than $35.00; and

(b) gaseous and liquid oxygen provided more than three months after the date of the physician's initial prescription.

(2) Rental of the following requires prior authorization:

(a) gaseous- and liquid-oxygen delivery systems after a rental period of three months;

(b) aspirators after a rental period of three months;

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(c) nebulizers after a rental period of three months;
(d) intermittent positive pressure breathing (IPPB) machines after a rental period of three months;
(e) oxygen-generating devices; and
(f) all other rental equipment.

(E) Requests for Prior Authorization. Instructions for the completion of the prior authorization form for oxygen are in Subchapter 5 of the *Physician Manual*. Before determining the medical necessity of the items or services for which prior authorization is requested, the Division may, at its discretion, require the prescribing physician to submit an assessment of the recipient's pulmonary condition on a patient respiratory evaluation form supplied by the Division.

(1) All prior authorization requests for oxygen and oxygen-generating devices must be accompanied by the results of an arterial blood gas analysis performed within the six weeks preceding the date of the request. This analysis should be performed while the recipient is in a stable chronic condition.

(2) All prior authorization requests for respiratory therapy equipment must be accompanied by the results of a pulmonary function test performed within the six weeks preceding the date of the request.

433.470: Transportation Services

Transportation services are reimbursable only when a recipient is traveling to obtain medical services that are reimbursable under the Medical Assistance Program.

(A) Eligible Recipients. The Division pays for transportation services for Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Service Limitations.

(1) Recipients must use transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a recipient must use public transportation, if available in the recipient's locality and suitable to his or her medical condition. Private transportation is reimbursable only when public transportation suitable to the recipient's medical condition is unavailable.

(2) In general, the Division will pay for a recipient to be transported to sources of medical care only within the recipient's locality. Locality refers to the town or city in which the recipient resides and to immediately adjacent communities. However, when necessary medical services are unavailable in the recipient's locality, medical transportation to the nearest medical facility in which treatment is available is reimbursable. If referral outside the recipient's locality is indicated, it is necessary for the physician to supply the recipient's Welfare Service Office with the documentation substantiating this need before authorization can be granted.

(C) Physician Authorization.

(1) Taxi and Dial-a-Ride Transportation. Taxi and dial-a-ride transportation require a prescription written by a physician or dentist on the Prescription for Taxi or Dial-a-Ride Transportation (PT-1) form. (Instructions for obtaining the form are in Subchapter 5 of the *Physician Manual*.)

(2) Ambulance and Chair-Car Transportation. The physician or the physician's designee who requests an ambulance (on a nonemergency basis) or chair car for a recipient must complete a Medicare/Medicaid Medical Necessity form at the time of the recipient's transfer, stating the specific physical disability that necessitates the requested mode of transportation. If the form is not completed by the physician, the physician's name must be entered on the form where indicated and the authority of the designee must be noted.

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Information given on the Medical Necessity form must be supported by the recipient's medical record. Emergency ambulance trips do not require a prescription. However, the nature of the emergency must be supported by medical records at the hospital to which the recipient was transported. (Instructions for obtaining the Medicare/Medicaid Medical Necessity form are in Subchapter 5 of the *Physician Manual*.)

(3) Multiple Trips. When a recipient must travel eight or more times per month to the same destination for a period of two months or more, a physician may authorize all trips for one month (any 30-day period) on one Medical Necessity form. The dates of each trip and the total number of trips must be entered on the form.

(4) Other Forms of Transportation. Other forms of transportation (for example, train, boat, and plane) are reimbursable only if prior authorization is obtained from the recipient's Welfare Service Office or Community Service Area Office.

(D) Recipient Reimbursement. The Division will reimburse a recipient directly for expenses incurred in traveling to reimbursable medical care only if the recipient's physician, registered nurse, licensed practical nurse, or medical facility social worker documents that reimbursable services were received. The documentation must include the following:

(1) the services that were provided;
(2) the date on which services were provided;
(3) the address where services were provided;
(4) the time services were provided, in cases of urgent medical need; and
(5) a statement that the services could not be obtained locally, if the recipient traveled outside his or her locality.

433.471: Therapy, Speech and Hearing Clinic, and Amputee Clinic Services

The Division pays for basic restorative services (therapy, speech and hearing clinic, and amputee clinic services) to reduce physical disability and to restore the recipient to a satisfactory functional level. Only those services that have the greatest potential for long-term benefits are reimbursable. The Division will not pay for medically unnecessary or experimental services.

(A) Eligible Recipients. The Division pays for restorative services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Physical, Occupational, and Speech Therapy.

(1) Physician Authorization.

(a) Physical and occupational therapy require a written referral from a licensed physician prior to the recipient's evaluation or treatment. The physician's orders for physical and occupational therapy must be renewed in writing every 30 days as long as the recipient is undergoing treatment.

(b) Speech therapy requires the written recommendation of a licensed physician or dentist prior to the recipient's evaluation or treatment.

(2) Service Restrictions. Maintenance therapy is not reimbursable. Only those therapy services that have a specific functional goal are reimbursable.

(C) Speech and Hearing Clinic Services. The recipient must be examined by an ear specialist (an otologist or an otolaryngologist) before referral is made to a speech and hearing clinic approved by the Division. If a hearing aid is indicated, a medical clearance stating that the recipient has no medical conditions to contraindicate the use of a hearing aid must accompany the referral.

(D) Amputee Clinic Services. An amputee clinic provides the following services: complete medical evaluation of the recipient's need for an artificial limb (prosthetic device); counseling concerning the use of the device; prescription of the device; referral to a certified prosthetic company; and follow-up evaluation. The Division will pay for a prosthetic device only when it is prescribed by an amputee clinic approved by the Division.

433.472: Mental Health Services

130 CMR 433.472 describes the range of mental health services reimbursable under the Medical Assistance Program.

(A) Eligible Recipients. The Division pays for the mental health services described in 130 CMR 433.472 for Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Mental Health Center Services. It is appropriate to refer a recipient to a mental health center when the recipient is no longer able to maintain his level of functioning and must seek professional help. Referral for treatment in a clinic setting is appropriate when the individual is not harmful to himself or to others and can maintain himself in the community even if at a diminished level of functioning.

(1) The Division will pay for mental health center services furnished by freestanding mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when the Division has certified the provider to perform mental health center services.

(2) Mental health center services are reimbursable only when provided by psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors (with a master's or doctoral degree in counseling education or rehabilitation counseling), or occupational therapists.

(3) Mental health center services include diagnosis and evaluation, case consultation, medication, psychological testing if done by a licensed psychologist, and individual, couple, family, and group psychotherapy.

(C) Mental Health Practitioner Services. A recipient may be referred to a private mental health practitioner (a licensed physician or a licensed psychologist) for the same reason that he may be referred to a mental health center. Mental health practitioners provide services that are more specialized and less comprehensive than the treatment and support services provided in mental health centers.

(1) The only mental health practitioners who can receive direct payment under the Medical Assistance Program for diagnostic and treatment services are licensed physicians (*see* 130 CMR 433.428 and 433.429).

(2) The Division will pay licensed psychologists only for providing psychological testing. The Division will not pay psychologists for providing psychotherapy, even under the supervision of a psychiatrist.

(D) Psychiatric Hospital Services. When a psychiatric recipient requires 24-hour management because he may be harmful to himself or to others, or if he is unable to maintain himself in the community, inpatient psychiatric services may be appropriate.

(1) The Division will pay for inpatient psychiatric hospitalization only when provided to:

(a) a recipient 65 years of age or older in a psychiatric hospital participating in the Medical Assistance Program; or

(b) a recipient of any age in a licensed and certified general hospital with or without an inpatient psychiatric unit.

(2) The services of an inpatient psychiatric unit include medication, individual and group therapy, milieu activities, and 24-hour observation provided by an interdisciplinary team.

(E) Psychiatric Day Treatment Services. Some recipients require the structure and support of a psychiatric treatment center, but do not require the overnight care provided by hospitalization. Accordingly, the recipient must have a suitable place to live while attending a psychiatric day treatment program. A psychiatric day treatment program may not adequately meet the needs of actively suicidal, homicidal, severely withdrawn, or grossly confused and disoriented individuals who cannot be maintained by family or friends and who are unable to travel to such a program. The Division will pay for psychiatric day treatment services provided by freestanding mental health centers, hospital-licensed health centers, hospital outpatient departments, or other facilities only when the Division has certified the provider to perform psychiatric day treatment services.

433.476: Alternatives to Institutional Care: Introduction

In recent years, new parts of the Medical Assistance Program have been designed and implemented to help elderly and disabled recipients remain in the community and avoid unnecessary or premature institutional placement. These include home health, adult day health, adult foster care, private duty nursing, independent living, intermediate care for the mentally retarded, and day habilitation. Decisions regarding institutional placement are made by the recipient, his family, his physician, and hospital continuing-care personnel. The physician's role can often be the most influential. For this reason, it is important for the physician to be aware of the alternatives to institutional long-term care. A network of community-based support services that did not exist previously in any quantity or quality is now available in many areas of Massachusetts. Only if physicians become aware of and support the use of such services will the use of institutional services be reduced. For information on services available in your area, contact the Medical Division's Noninstitutional Long-Term Care Unit at the address and telephone number in Appendix A of the *Physician Manual*.

433.477: Alternatives to Institutional Care: Adult Foster Care

(A) Program Definition. Adult foster care is designed to provide a family-like environment for an adult who otherwise would be in a level II or III nursing home. Each foster family may care for a maximum of two participants (elderly or disabled adults). The foster family provides 24-hour supervision and assistance with such activities of daily living as bathing, dressing, and self-administration of medications. Community support is available from such organizations as certified home health agencies and adult day health programs.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for adult foster care.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Physician Responsibilities.

(1) Each recipient must have medical clearance prior to placement in a foster home.

(2) The recipient's physician is required to provide documentation of the following: a physical examination conducted within the preceding three months; current treatment including medications and diet; and a description of any physical or emotional limitations that may preclude participation in activities.

(3) The physician, with the certified home health agency nurses, must maintain follow-up care of the recipient.

433.478: Alternatives to Institutional Care: Home Health Services

(A) Program Definition. Home health agencies provide health and support services in the home for elderly and disabled persons who wish to remain in their homes rather than to enter an institution. These services are available between 8:00 A.M. and 9:00 P.M., and homemaker/home health aide services are available on a 24-hour or short-term basis. All services are available seven days a week. All home health agencies provide nursing and homemaker/home health aide services; in addition, most agencies provide physical, occupational, and speech therapy. The Division pays only Medicare-certified home health agencies, frequently called visiting nurse associations.

(B) Eligible Recipients. The Division pays for home health services for Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

433.478: continued

(C) Physician Responsibilities. Any physician who believes that a recipient needs home health services should call the home health agency directly or send written orders. A recipient seen by the agency must have written orders from his or her physician; these orders must be updated and recertified every 60 days.

433.479: Alternatives to Institutional Care: Private Duty Nursing Services

(A) Program Definition. A private duty nurse is a registered nurse or a licensed practical nurse who independently contracts to provide nursing services to patients who, without such services, might be institutionalized. The Division will pay for nursing care in the recipient's home when private duty nursing services are less costly than institutional placement, provided that the professional services are medically necessary. This program provides alternative care to those home-bound recipients whose medical and nursing needs cannot be met by a home health agency, adult day health program, or support services.

(B) Eligible Recipients. The Division pays for private duty nursing services for Medical Assistance recipients (catagories of assistance 00, 01, 02, 03, 05, 06, 07, 08) not residing in a hospital or long-term-care facility. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Prior Authorization Requirements. Prior authorization must be obtained from the Division before private duty nursing services are reimbursable. The attending physician and nurse must document the following: diagnoses, treatment plan, functional limitations, estimated length of service, and description of the recipient's social situation.

(D) Physician Responsibilities. The recipient's attending physician must sign the patient care plan documenting the medical necessity for private duty nursing services.

433.480: Alternatives to Institutional Care: Adult Day Health Services

(A) Program Definition. An adult day health program is a structured program of health care and socialization designed to meet the needs of persons who otherwise might be institutionalized. Adult day health services also enable some individuals who have been institutionalized to return to community living. Adult day health programs are based in a center and may be free-standing or located in nursing homes or hospitals. Staff members of the program make arrangements for transportation to and from the center, depending upon community resources and the recipient's needs. The program offers the participant professional supervision, observation, and preventive health care including medical, therapeutic, restorative, counseling, and nutrition services. In addition, the program offers planned educational, recreational, and social activities. These services are provided to maintain the participant at his or her highest level of functioning, thereby preventing or delaying institutionalization. The program offers the participant's family relief from 24-hour supervision and caretaking. Adult day health programs also provide counseling to family caretakers to help them cope with their family situations.

(B) Eligible Recipients.
(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for adult day health services.
(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Physician Responsibilities.
(1) Each recipient accepted into an adult day health program must have a complete physical examination within the three months preceding the recipient's first program attendance day.